Benefit Void/Reissue Form

Participant Name: _____ **Participant ID#**: _____

Clinic Name/Number: _____ **Date of Void/Reissue**: _____

Benefit to be voided:

_____ _____

_____ _____

_____ _____

Benefits that were reissued:

_____ _____

_____ _____

_____ _____

Number of cans of formula and type of formula returned: _____

Was any cereal or juice returned? Y or N If yes, how much? _____

Reason for void/reissue: _____

_____

_____

_____

_____

INSTRUCTIONS: Complete this form with every void/reissue involving a USED formula food package change. Place one copy in the client's chart and send the original to the State WIC Office, PO BOX 202951, Helena MT 59620.

Clinic Signature_____ **Date**_____